Mississippi State Department of Health
Office of Rural Health
Medicare Rural Hospital Flexibility Program (*FLEX)*
STATE RURAL HEALTH PLAN

INTRODUCTION AND PURPOSE OF PLAN

Section 4201 of the Balanced Budget Act of 1997 (Public Law 105-33) sets forth rules for the Medicare Rural Hospital Flexibility Program (FLEX). The Mississippi Office of Rural Health (MORH) at the Mississippi State Department of Health (MSDH) administers the Medicare Rural Hospital Flexibility Program for Mississippi. The purpose of the FLEX Program is to help sustain the rural health care infrastructure, with Critical Access Hospitals (CAHs) serving as the hub of an organized system of care for small rural communities. CAHs are acute care facilities that provide outpatient, emergency, and limited inpatient services and are recognized as a new provider type eligible for cost-based Medicare reimbursement. Some additional requirements for CAHs include being located in a rural area, operating a maximum of 25 acute care beds, having an average inpatient stay of 96 hours, having a referral network agreement, and providing emergency care 24 hours a day. CAHs can also participate in swing bed programs, which allow acute care beds to alternate as needed between acute care and long-term care in hospitals of fewer than 100 beds. Mississippi has 27 hospitals designated as CAHs. In addition to the designation of hospitals as CAHs, the FLEX Program also allows states to engage in rural health network development and support, hospital quality improvement initiatives, CAH support, and emergency medical services (EMS) activities.

The Federal Office of Rural Health Policy (ORHP) required states seeking funding to organize FLEX Programs to develop FLEX State Rural Health Plans (SRHP) to guide the activities of those programs; the MSDH approved the original FLEX SRHP in January 1999 and submitted it to the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services). ORHP is now requiring the plan to be updated to provide direction for the current three-year FLEX Program Competitive Funding Cycle (2007-2010).

This plan is being submitted to ORHP on behalf of the state of Mississippi for the state's Medicare Rural Hospital Flexibility Program. It has been revised by the MSDH, Office of Rural Health, in consultation with the Mississippi FLEX State Rural Health Plan Steering Committee. The committee was comprised of representatives from the Mississippi Hospital Association, State Quality Improvement Organization, Mississippi State Department of Health Division of Licensure and Certification, Mississippi State Department of Health Bureau of Emergency Medical Services, CAHs and Eligible CAHs, Mississippi Rural Health Association, Mississippi Insurance Department Fire Services Development Division, and the Delta Health Network. This plan contains information related to Mississippi's demographic, economic, health status, and health facilities and systems characteristics. In addition, the plan includes an overview of the state's health manpower, emergency medical services, critical access hospitals, and the Flex Program Strategic Planning Process and FLEX Program Objectives.

SECTION I
STATE PROFILE

A. Geographic Description of State

Mississippi is one of the most rural states in the nation in terms of the percentage of persons residing in rural areas (56%), and 65 of the state's 82 counties are designated rural. The Mississippi Office of Rural Health defines rural population as those living in counties without a Metropolitan Statistical Area (MSA). APPENDIX A provides a geographical view of the rural areas in the state, which represent 79% of the counties in Mississippi. A list of rural counties in Mississippi is available in APPENDIX B.

Mississippi is bounded on the north by Tennessee, on the east by Alabama, on the west by Arkansas and Louisiana, and on the south by the Gulf of Mexico. Mississippi contains 47,715 square miles of area, mostly rural farmland. In the north, the large, fertile alluvial Delta was mostly swamp until the mid-1850s when, by the sweat of men and mules, some 300 miles of levees claimed this broad region. At the Delta's eastern edge, the land suddenly changes from table-flat to the rising loess bluff hills, stretching north into Tennessee and south into Louisiana. From Mississippi's northeast hills southward, the land changes into rolling farmland, hardwood highlands, then red clay hills to fertile pasture lands, on to piney forest, eventually giving way to the man-made white sand beaches of the Gulf Coast.

B. Population Distribution and Demographics

The 2007 United States (U.S.) Census Estimate reported Mississippi's population as 2,918,785. Mississippi's population is dispersed throughout 82 counties and 296 incorporated cities, towns, and villages. The state has four MSAs: Gulfport-Biloxi (Hancock, Harrison, and Stone counties); Pascagoula (Jackson and George counties); Jackson (Hinds, Madison, Rankin, Copiah, and Simpson counties); and Hattiesburg (Forrest, Lamar, and Perry counties). There are also four Mississippi counties (DeSoto, Marshall, Tate, and Tunica) included in the Memphis MSA.

The 2007 Census Estimate reports that the state's gender composition was 48.4 % male and 51.6 % female. The racial composition was 60.7% white, and 39.3% non-white. The median age is 35.2 years and persons aged 65 or older made up 12.5 % of the population.

Seventy-three percent of Mississippians over the age of 25 are high school graduates or higher and 16.9 % of Mississippians in this age group have a bachelor's degree or higher. Both levels are less than the respective national average at 80.4 % and 24.4 %.

C. Mississippi Economic Data

Mississippi ranked 49th among the states in per capita income and 48th in median family income, according to the 2006 Census data. The per capita income for Mississippi was

$18,165 and the median family income was $42,805. These levels for the nation were $25,267 and $58,526 respectively.

The top five employing industries in the state are manufacturing, health care and social assistance, retail trade, accommodation and food services, and education services. The mining industry had the fewest number of employees. The Mississippi Employment Security Commission reported an average citizen labor force of 1,314,800 with an unemployment rate of 6.3% for 2007. By September 2008, the state rate had risen to 7.4%. Seventeen counties reported double- digit unemployment rates, and 27 counties had unemployment rates less than or equal to the state rate. Rankin County had the lowest unemployment rate in the state at 4.1%, and Noxubee County had the highest at 14.1%.

D. Health Status of Mississippians

Mississippi is a medically underserved state, with many rural areas. Statistics present an extremely negative view of the overall health in Mississippi, as has been the case historically. Compared to national health statistics, Mississippi's residents rank lowest in several overall health indicators.

According to the 2007 Mississippi Vital Statistics Report, prepared by the Mississippi State Department of Health (MSDH), Mississippi experienced 46,455 live births and the fertility rate was 76.8. At least 22.8 % of births were immature (less than 2,500 grams) and/or premature (gestation less than 37 weeks), and 546 congenital anomalies were reported. There were 477 deaths of infants (children less than one year of age) during 2007 for an infant mortality rate of 10.3.

There were 27,994 total deaths in Mississippi reported for 2007. The ten leading causes of deaths in Mississippi resulted in 78.2% of all deaths and included heart disease; malignant neoplasm; accidents; cerebrovascular disease; emphysema and other chronic lower respiratory disease; Alzheimer's disease; diabetes mellitus; nephritis, nephrotic syndrome, and nephrosis; influenza and pneumonia; and septicemia.

The 2007 prevalence of diabetes in Mississippi was 11.1 %; the prevalence level ranked among the highest in the nation. Diabetes is one of the primary causes of stroke, adult blindness, end-stage renal disease, and non-traumatic lower extremity amputations. It is an important risk factor for coronary heart disease, and various complications of pregnancy.

Cardiovascular disease (CVD) includes coronary heart disease, stroke, complications of hypertension, and diseases of the arterial blood vessels and caused almost half of all deaths in Mississippi. Stroke alone disables almost 2,000 Mississippians each year. Hypertension (high blood pressure) is a major risk factor for coronary heart disease (CHD) and heart failure, and it is the single most important risk factor for stroke. Mississippi is one of 11 states in the southeast region of the U.S. known as the "Stroke

Belt"; this region has had higher stroke death rates than other U.S. regions for at least 50 years.

The Mississippi Workers Compensation Commission's *2007 Annual Report of Occupational Injuries and Illnesses* reported 12,369 work-related injuries or illnesses. Most major workplace injuries or illnesses occurred on Monday. There were 81 fatalities as a result of work-related injuries or illnesses.

SECTION II
THE ORGANIZATION AND SUPPORT OF RURAL HEALTH SYSTEMS IN MISSISSIPPI

Mississippi is committed to assisting communities in determining the best course of action in planning and developing rural health systems, including plans that improve access to health services, reduce duplication of services, and develop and support rural health networks. The Mississippi Public Health System is led by the MSDH, an agency which includes an 11-member Board of Health, State Health Officer, central administrative offices in Jackson, nine district offices, and 81 county health departments. The MSDH promotes and protects the health of the citizens of Mississippi through health promotion, disease prevention, and the control of communicable diseases. This section describes some of the types of public rural health facilities and systems in Mississippi that comprise the rural health infrastructure.

A. Facilities

1. Hospitals

Mississippi had 98 non-federal medical/surgical hospitals in June 2008, with a total of 11,074 licensed acute care beds (plus 136 beds held in abeyance by the MSDH). This total also includes one rehabilitation hospital with acute care beds and one OB/GYN hospital. This total excludes long term acute care (LTAC), rehabilitation, psychiatric, chemical dependency, and other special purpose beds.

As stated earlier in the introduction, 27 of the 98 hospitals have been designated as CAHs. These hospitals provide outpatient, emergency, and limited inpatient services, and receive cost-based reimbursement for services provided to Medicare patients. Some requirements for CAHs include being located in a rural area, operating a maximum of 25 acute care beds, having an average inpatient stay of 96 hours, a referral network agreement, and the availability of emergency care 24 hours a day. CAHs can participate in swing bed programs. Swing bed programs allow acute care beds to alternate as needed between acute care and long-term care in hospitals of fewer than 100 beds. CAHs are discussed further in Section V.

In addition to the state’s non-federal hospitals, the federal government operates two Veterans' Administration Hospitals, one in Jackson and one in Biloxi. The United States Air Force operates medical facilities at Columbus and Biloxi to serve active duty and retired military personnel and their dependents. The Indian Health Service funds the operation of the Choctaw Health Center, an 18-bed acute care hospital in Philadelphia which is operated by and provides health care services to the Mississippi Band of Choctaw Indians.

Acute care hospitals had 427,781 admissions, 403,467 discharges, and 1,962,691 inpatient days during 2007. They had 421,925 admissions, 397,759 discharges, and

1,980,399 inpatient days during 2006. The following seven counties do not have a hospital: Amite, Benton, Carroll, Issaquena, Itawamba, Kemper, and Tunica counties.

Currently, 72 of the 98 non-federal acute care hospitals in the state are in rural areas (located outside of Metropolitan Statistical Areas). These 72 hospitals represented 55 percent of the total number of licensed acute care beds in 2007. Of these hospitals, 53 (73.6 percent) have fewer than 100 beds, and 40 (55.60 percent) have fewer than 50 beds. In 2007, 39 of the rural hospitals with fewer than 100 beds reported occupancy rates of less than 40 percent; seven reported occupancy rates of less than 20 percent.

2. Local Health Departments

The MSDH operates at least one county health department in every county, with Sharkey and Issaquena counties sharing a health department. These 81 county health departments have more than 100 clinic sites throughout the state. Department staff includes public health nurses, nurse practitioners, physicians, disease investigators, environmentalists, medical records clerks, social workers, and nutritionists. The county health departments provide immunizations, family planning, WIC (Special Supplemental Food Program for Women, Infants, and Children), tuberculosis treatment and prevention services, sexually-transmitted disease (including HIV/AIDS) services, and other communicable disease follow-up. Additional services, such as child health and maternity services, are available based on the county's need. The number and type of staff may vary according to the need and resources in each particular county; however, every county provides all general public health services.

3. Rural Health Clinics

Rural Health Clinics (RHCs) provide care in areas designated by the U.S. Department of Health and Human Services as medically underserved. These clinics use physician’s assistants and nurse practitioners under the general direction of a physician, who is located within 15 miles of the clinic, to provide outpatient primary care services to patients in rural areas. RHCs may be freestanding facilities owned by physicians or provider-based clinics established by hospitals, nursing homes, or home health agencies. There were 60 hospital-based RHCs, with 614,173 visits in Mississippi in 2007, according to the Mississippi 2007 Report on Hospitals.

4. Community Health Centers (CHCs)

The availability and accessibility of primary health care services is essential to meet the needs of the state’s population. Community Health Centers (CHCs) provide access to medical care for residents who are plagued by a shortage of medical services, financial restrictions, and other social or economic barriers. CHCs are federally-subsidized, non-profit corporations that must serve populations identified by the U.S. Department of Health and Human Services as medically underserved. This status indicates that the geographic area has limited medical resources; other factors include poverty and lack of

health insurance. CHCs offer a range of services, including medical, dental, radiology, pharmacy, nutrition, health education, and transportation. Mississippi has 22 CHCs, with 154 sites.

5. Long-Term Care

There were 210 nursing home sites and 61 home health agencies listed in the MSDH's 2007 Facilities Directory. The state has 13 intermediate care facilities for the mentally retarded (five proprietary and eight state owned and operated). There are also six operational psychiatric residential treatment facilities for emotionally disturbed children and adolescents. Some Mississippi hospitals provide limited nursing home care in "distinct part skilled nursing facilities." These units are located in a physically identifiable distinct part of the hospital and are certified for participation in the Medicare program as skilled nursing facilities. Some hospitals offer care in "swing beds", which are beds approved to alternate as needed between acute care and long-term care in hospitals of fewer than 100 beds.

6. Mental Health

The Mississippi Department of Mental Health (MDMH) administers four state psychiatric hospitals, six crisis intervention centers, five residential centers for persons with mental retardation, community mental health and mental retardation services for children and adults, and a variety of alcohol and drug prevention and treatment programs. The MDMH also develops day programs and caregiver training for individuals with Alzheimer's disease/other dementia and serves as the Designated State Agency (DSA) for the Mississippi Council on Developmental Disabilities. Through contracts and affiliations with the state's community mental health/mental retardation centers and other public and private agencies, the MDMH strives to ensure a continuum of community prevention, treatment, training, and support services. The MDMH offers a range of services to persons with mental retardation and developmental disabilities through a variety of programs, including early intervention programs, alternative living arrangements, work activity centers, and long-term residential care. In addition to the MDMH, 15 regional community mental health/mental retardation centers and their satellite facilities, as well as other non-profit programs, provide a network of services throughout the state. Mississippi has 12 hospital-affiliated and three freestanding facilities providing psychiatric care. There are 12 facilities offering chemical dependency services, six freestanding psychiatric residential treatment facilities offering long-term care to emotionally disturbed children and adolescents who need restorative residential treatment services.

B. Public Health Systems (Medicare, Medicaid, and SCHIP)

Medicare, a third party federally-administered program, provides payments for hospital, physician, and other medical services for most persons 65 years of age and older and disabled persons entitled to Social Security cash benefits for 24 months. Medicare consists of two parts:

compulsory hospitalization insurance (Part A) and voluntary supplemental medical insurance (Part B), which covers physician services and some medical services and supplies not covered by Part A.

Medicaid is another third party reimbursement program providing health care services for eligible persons. The Mississippi Division of Medicaid, Office of the Governor, administers state appropriated funds and federal matching funds within the provisions of Title XIX of the Social Security Act, as amended, to provide medical assistance for needy Mississippians. Medicaid includes 12 mandatory services and 24 optional services. The mandatory services include: inpatient hospital services, other than institutions for mental disease; outpatient hospital; rural health and federally qualified health center clinic services; other laboratory and x-ray services; skilled nursing facility services for individuals age 21 and older; physician services, family planning services and supplies; EPSDT (Early and Periodic Screening, Diagnostic and Treatment) services, home health services for persons eligible for nursing facility services; nurse-midwife services to the extent allowed by state law; pediatric and family nurse practitioner services; medical and surgical dental services; and transportation services.

The State Children's Health Insurance Program (SCHIP) is a separate health insurance program that covers non-Medicaid children up to 200 % of the federal poverty level (FPL). Currently, SCHIP targets all children in the state under age 19 who are below 200 % of the federal poverty level, not eligible for Medicaid coverage, and have no other health coverage.

SECTION III
HEALTH MANPOWER

High quality health care services depend on the availability of competent health personnel in sufficient numbers to meet the population's needs. Mississippi is traditionally a medically underserved state, particularly in rural areas and areas containing large numbers of poor people, elderly people, and minorities. A review of the Health Resources and Services Administration, Shortage Designation Branch listing of Health Professional Shortage Areas (HPSAs) indicates that 75 of Mississippi's 82 counties are currently designated as HPSAs in whole or in part. In addition, the state has 74 dental shortage areas which include 72 single county designations, and 13 of 15 catchment areas designated for mental health. Essential health service delivery requires an adequate supply and appropriate distribution of fully qualified physicians, dentists, pharmacists, nurses, and other health personnel. The Office of Primary Care Liaison, Mississippi Office of Rural Health and the University of Mississippi Medical Center engage efforts to alleviate shortages through recruitment of physicians, dentists, nurse practitioners, mental health providers, and EMS providers.

Mississippi had 5,098 active medical doctors, 264 osteopaths, and 59 podiatrists licensed by the Board of Medical Licensure for licensing year 2006, for a total of 5,421 active licensed physicians practicing in the state. Approximately 46% of Mississippi's Family Practice, General Practice, Internal Medicine, Obstetrics, and Gynecological and Pediatric physicians practice in rural counties. Mississippi had 34,796 registered nurses and 1,803 nurse practitioners in 2007 according to the Mississippi Board of Nursing Annual Report. The Mississippi Nurses' Association (MNA) and 25 nursing organizations are working together through the MNA's Nursing Organization Liaison Committee to address nursing manpower issues related to anticipated changes in the workplace. The State Board of Pharmacy reported approximately 2,682 licensed pharmacists in the state during 2005, with an additional 958 pharmacists licensed in Mississippi but living in other states. The Mississippi State Board of Dental Examiners reported 1,407 licensed dentists in the state for 2006. Many rural areas still face a shortage of dentists. Approximately 43.5% of Mississippi's dentists practice in rural areas.

Emergency Medical Services (EMS) are health care services delivered under emergency conditions that occur as a result of a patient's condition, natural disasters, or other situations. EMS are provided by public, private, or non-profit entities with the authority and the resources to effectively administer services. Mississippi had 6,300 EMS certified personnel in state fiscal year 2006 (3,419 EMS Drivers, 1,655 Basic EMTs, 68 Intermediate EMTs, and 1,158 EMT Paramedics). Seventy-two percent of fire departments in rural communities provide EMS services. Data from the Mississippi Department of Insurance, Division of Fire Services Development Annual Fire Department Report, indicated that there were 519 fire departments in rural areas; of these 488 are volunteer departments. The 488 volunteer fire departments are staffed with 9,294 volunteers. The next section (Section IV) further discusses EMS.

SECTION IV
EMERGENCY MEDICAL SERVICES

As a primary source of pre-hospital care, EMS are an important part of health/medical care in rural communities. Quick access to health care in rural communities can be problematic, particularly given the higher levels of motor vehicle crash deaths, injuries, and fires. The Federal Government, through the Emergency Medical Services Act of 1973, established standards for the organization of emergency services. The Mississippi EMS Act of 1974, and subsequent amendments, authorized the MSDH to create a Bureau of Emergency Medical Services (BEMS). The Act authorized this Bureau to license all ambulance services in Mississippi, to require specific equipment and standards for emergency vehicles, to provide training and certification of emergency medical technicians (EMTs) and Medical First Responders, and to assist with the creation and the provision of technical assistance.

With the passage of legislation during the 1991 Mississippi Legislative Session, the MSDH was designated as the lead agency to develop a trauma care plan for the state. The primary goal of the Mississippi Trauma System Care Program is to provide the architecture for a trauma system which will decrease morbidity and mortality from traumatic injury. Acute care hospitals reported 1,669,557 emergency visits during 2006 and 1,726,950 visits in 2007. The BEMS also has an Emergency Medical Services for Children (EMSC) program that focuses on improving the quality of children's emergency care. The goals are to ensure that state-of-the-art emergency medical care is available for ill or injured children and adolescents, to ensure that pediatric service is well integrated into the emergency medical services system, and to ensure that the entire spectrum of emergency services including primary prevention of illness and injury, acute care, and rehabilitation, are provided to children and adolescents.

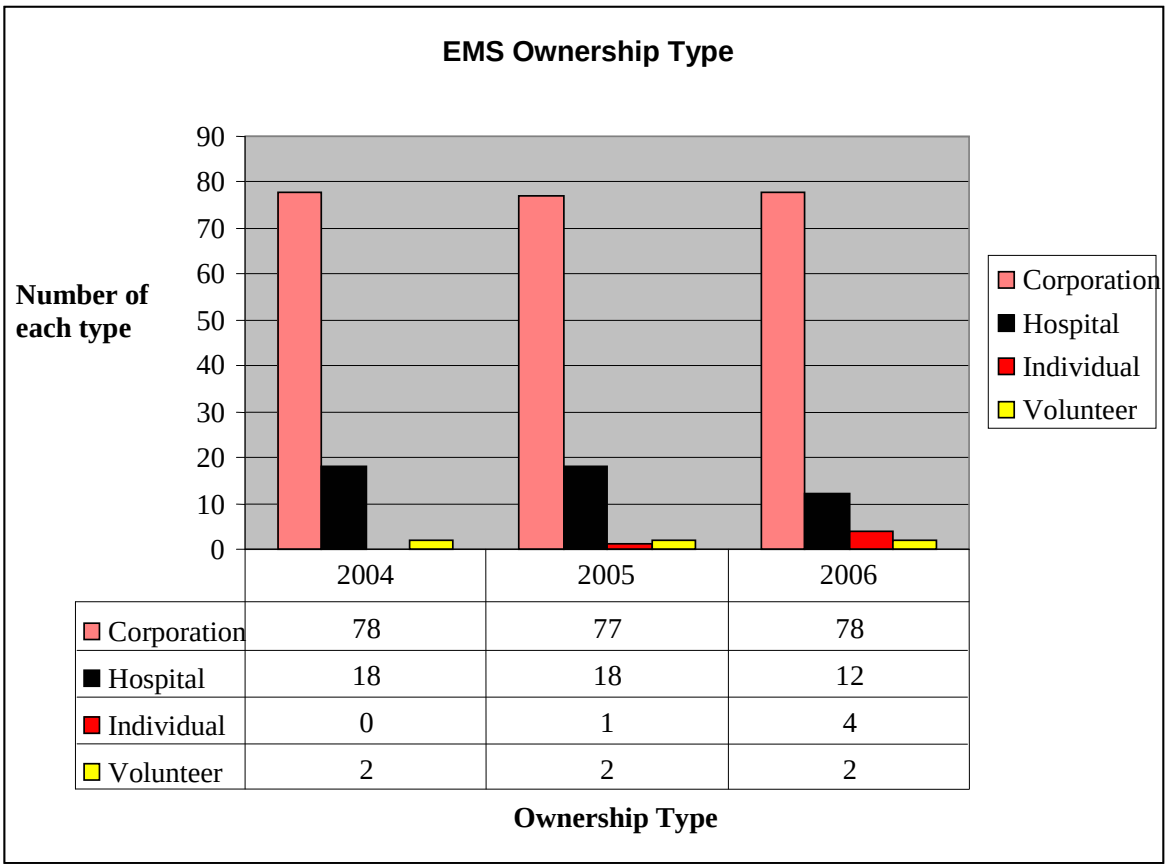
Many people with greatly diverse backgrounds and talents contribute to the EMS System in Mississippi. These include: bystanders, firefighters, law enforcement officers, emergency medical dispatchers, medical first responders, emergency medical technicians, nurses, physicians, and volunteers. EMS providers in Mississippi are certified by the BEMS. There are five levels of certified EMS providers. They are as follows:

- Medical First Responder
- Emergency Medical Services – Driver
- Emergency Medical Technician – Basic (EMT-Basic)
- Emergency Medical Technician – Intermediate (EMT Intermediate)
- Emergency Medical Technician – Paramedic (EMT-Paramedics)

Mississippi requires drivers of ambulance vehicles to be EMS-Driver certified. EMT-Intermediate training is no longer available in Mississippi, although there are individuals who are still certified at this level. Ten licensed providers offered air ambulance services in Mississippi during state fiscal year 2006. Mississippi had five helicopter air ambulance services based within the state in Hattiesburg, Tupelo, Jackson, Batesville, and Corinth. In addition, six out-of- state air ambulance services were licensed to serve the state. Ambulance services are licensed by location and permits are issued for each vehicle the service operates. Licenses are also issued for ground and air services.

CHART 1 below shows licensing information by ownership type for years 2004, 2005, and 2006. In 2006, Mississippi had 141 EMS providers licensed for the state.

CHART 1

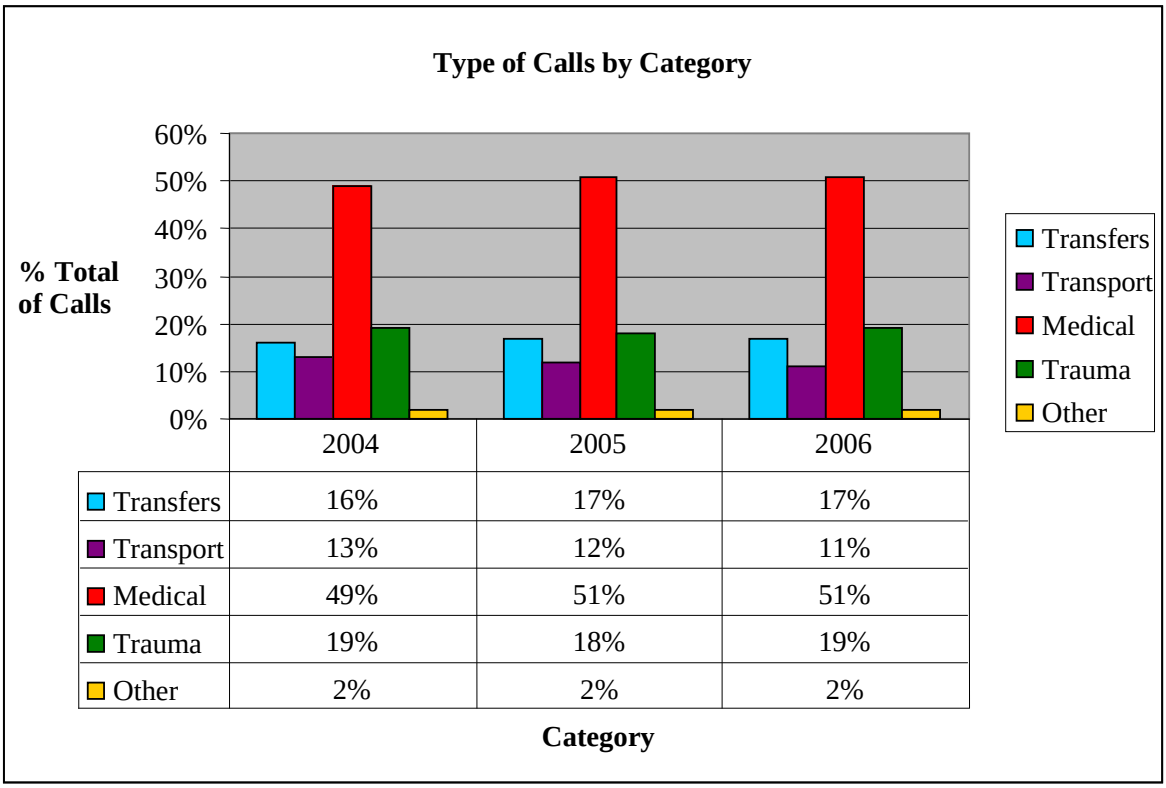


	2004	2005	2006
Corporation	78	77	78
Hospital	18	18	12
Individual	0	1	4
Volunteer	2	2	2

Totals	143	143	141

The Mississippi Emergency Medical Services Information System (MEMSIS) was established in 1992. MEMSIS is a paperless patient's encounter reporting system. All licensed ambulance service providers enter encounter information into a computer locally; the information is then transmitted to the state via modem. Mississippi providers responded to 291,006 calls in 2006. CHART 2 shows the calls by categories for 2004, 2005, and 2006.

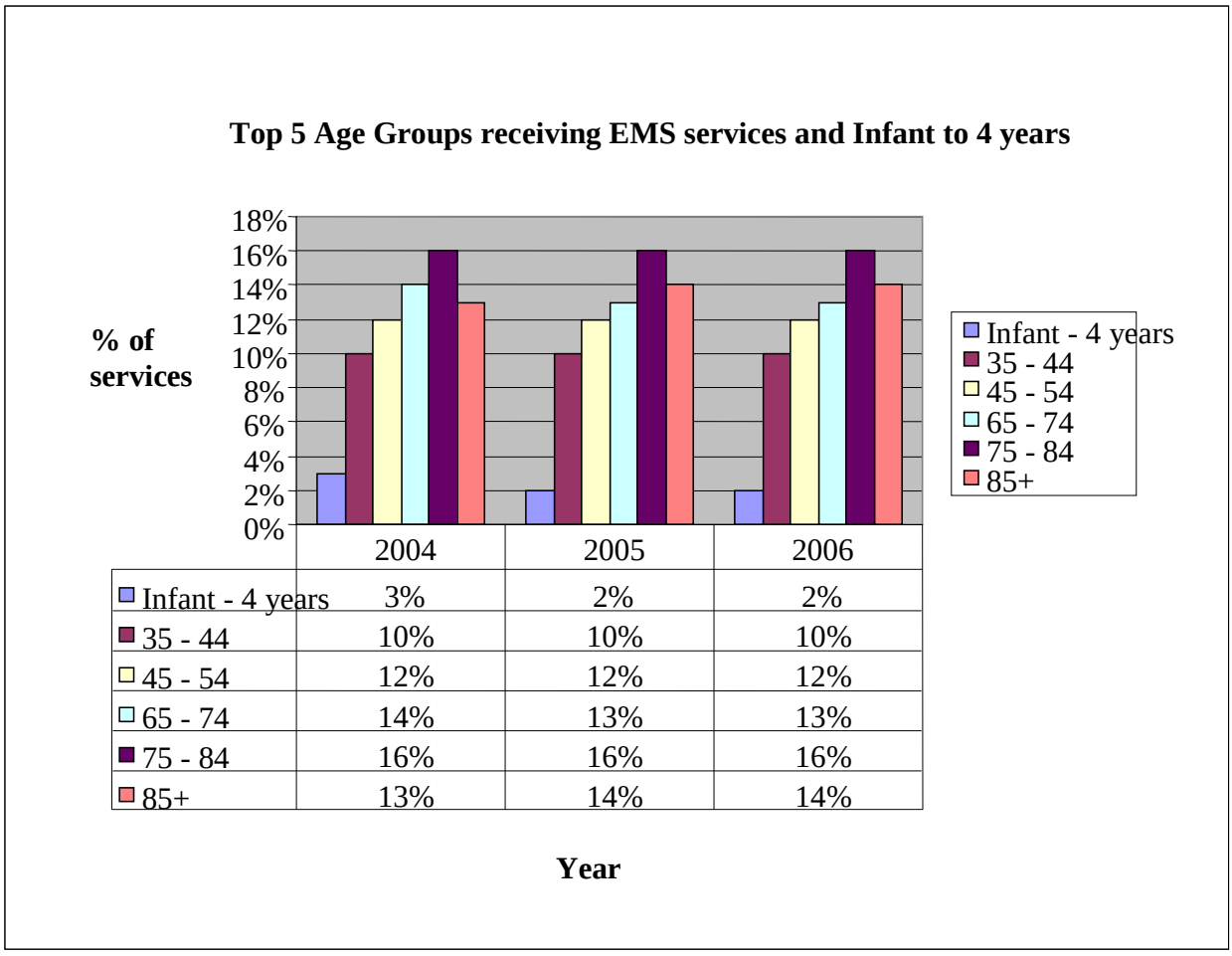
CHART 2



	2004	2005	2006
Transfers	16%	17%	17%
Transport	13%	12%	11%
Medical	49%	51%	51%
Trauma	19%	18%	19%
Other	2%	2%	2%

CHART 3 indicates that for years 2004, 2005, and 2006, the majority of emergency calls were for assistance for individuals aged 75 to 84. The largest volume of calls occurred on Fridays, followed by Mondays. The second largest number of calls to which EMS providers responded were for individuals aged 85 and older. The least number of emergency response calls were for children (infant to 4 years of age). The five year average response time (includes time provider receives dispatch, to time en route to scene, time on scene, and time en route to destination from scene) for trauma calls was 12.7 minutes. The five-year average response time for medical calls (for same indicators) was 19.8 minutes. The longest time incurred during response is the time en-route from the scene of the incidence to the destination.

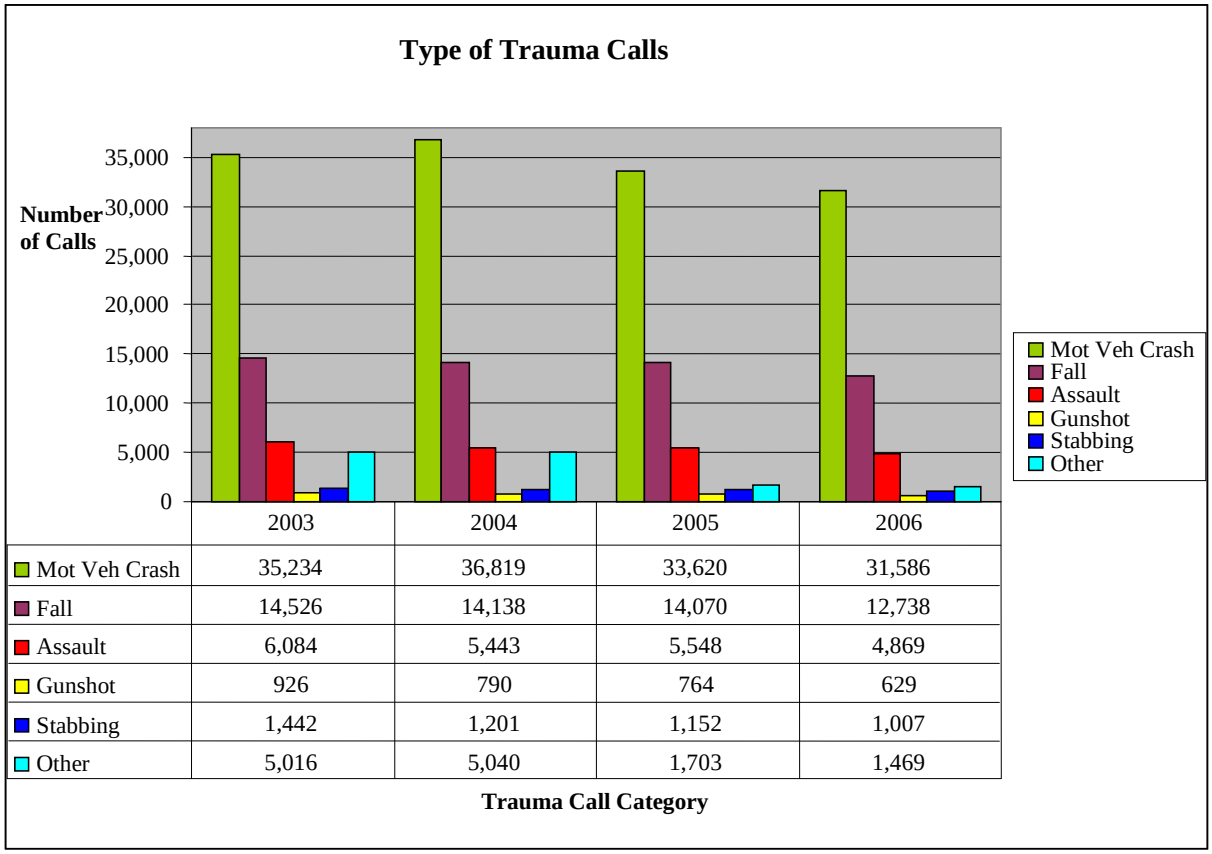
CHART 3



	2004	2005	2006
Infant - 4 years	3%	2%	2%
35 - 44	10%	10%	10%
45 - 54	12%	12%	12%
65 - 74	14%	13%	13%
75 - 84	16%	16%	16%
85+	13%	14%	14%

Since 2003, the majority of trauma emergency calls were related to motor vehicle crashes. Falls were the second leading type, followed by assaults. CHART 4 provides information on the types of trauma emergency calls from 2003 through 2006.

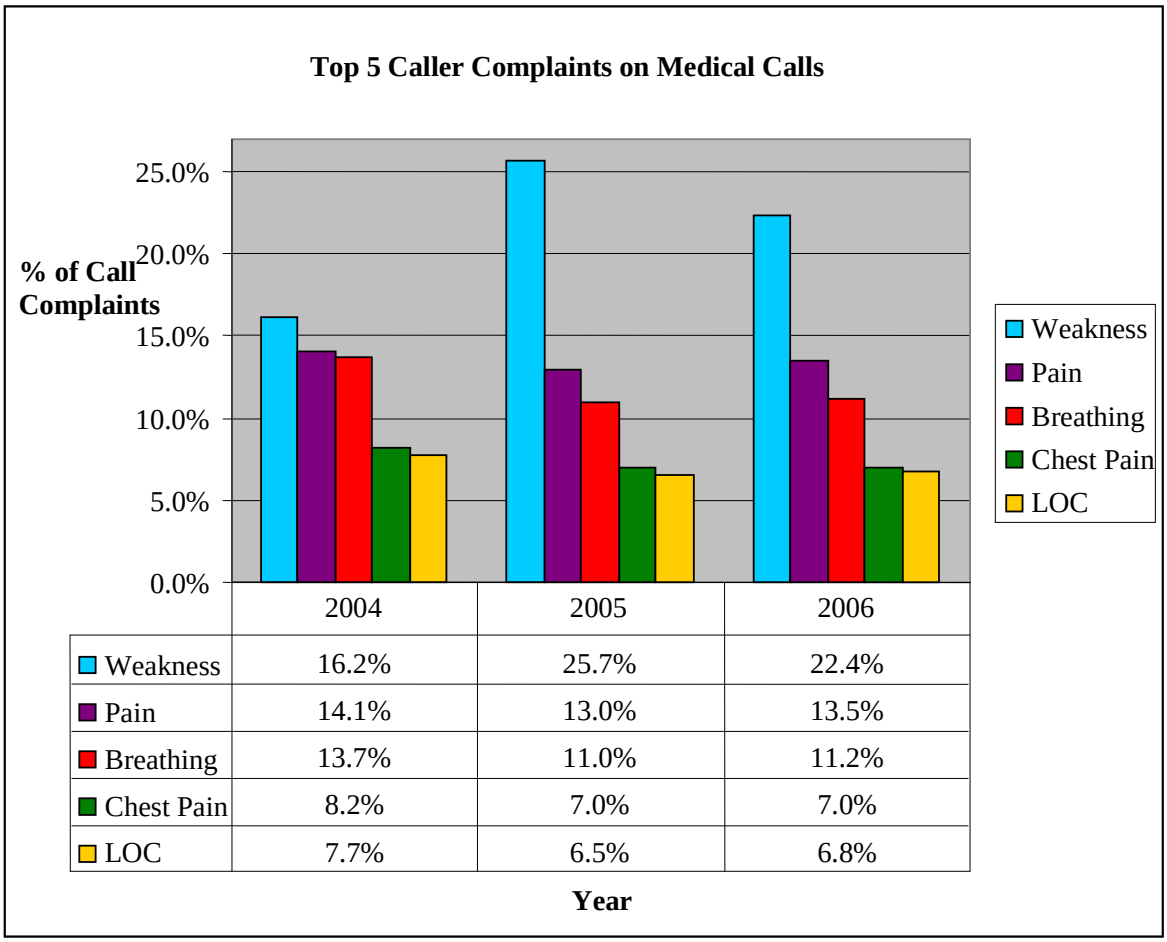
CHART 4



	2003	2004	2005	2006
Mot Veh Crash	35,234	36,819	33,620	31,586
Fall	14,526	14,138	14,070	12,738
Assault	6,084	5,443	5,548	4,869
Gunshot	926	790	764	629
Stabbing	1,442	1,201	1,152	1,007
Other	5,016	5,040	1,703	1,469

CHART 5 indicates that the top five complaints from callers of medical emergency calls were weaknesses, pain, breathing difficulty, chest pain, and altered level of conscientious (LOC). Weakness was the medical condition cited most often.

CHART 5



	2004	2005	2006
Weakness	16.2%	25.7%	22.4%
Pain	14.1%	13.0%	13.5%
Breathing	13.7%	11.0%	11.2%
Chest Pain	8.2%	7.0%	7.0%
LOC	7.7%	6.5%	6.8%

SECTION V
MISSISSIPPI RURAL HOSPITAL FLEXIBILITY PROGRAM AND CRITICAL ACCESS HOSPITALS

A. Mississippi Rural Hospital Flexibility Program

The Medicare Rural Hospital Flexibility Program (FLEX) is a federal initiative that provides funding to state governments to strengthen rural health. The purpose of the FLEX Program is to help sustain the rural healthcare infrastructure, with CAHs as the hub of an organized system of care, through mechanisms of the program. These mechanisms include the FLEX State Rural Health Plan (SRHP), CAHs, Networks, Quality Improvement, and EMS initiatives. The Mississippi Office of Rural Health at the MSDH administers the Medicare Rural Hospital Flexibility Program for the state of Mississippi. The FLEX Program goals include: 1) designation of hospitals as CAHs in the state; 2) development and support of Rural Health Networks for which CAHs are members; 3) support for existing CAHs and eligible hospitals; 4) improvement and integration of EMS services; and 5) improving quality of care. The 1998 session of the Mississippi Legislature authorized the MSDH to develop a FLEX State Rural Health Plan, to adopt rules and regulations for the designation of CAHs in the state. This section will provide information on CAHs, the CAH designation process, the CAH application, and objectives of the FLEX Program.

B. Critical Access Hospitals

CAHs are acute care facilities that provide outpatient, emergency, and limited inpatient services and are recognized as a new provider type eligible for cost based Medicare reimbursement. Currently, Mississippi has 27 hospitals designated as CAHs. Additional requirements for CAHs include being located in a rural area, operating a maximum of 25 acute care beds, having an average inpatient stay of 96 hours, having a referral network agreement, and providing emergency care 24 hours a day. CAHs can also participate in swing bed programs. Swing bed programs allow acute care beds to alternate as needed between acute care and long-term care in hospitals of fewer than 100 beds.

C. Profile of Mississippi Critical Access Hospitals

In 2007, of the 27 CAHs, five were for profit; 13 were run by the local government, not-for-profit; one was run by the state government; and eight were run by corporations which were also non-profit. The certification and accreditation of these hospitals consists of all 27 hospitals being endorsed by BlueCross BlueShield of Mississippi, Medicare, and Medicaid. Only four of these hospitals were accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO).

Total hospital personnel at CAHs were 4,187, with 2,848 full-time employees and 1,079 part-time employees. There were 66 total physicians (full and part-time) and 742

registered nurses (full and part-time). The total number of licensed practical nurses was 296 (216 full time and 85 part-time). Twenty-three CAHs had pharmacists (20 had full-time and 24 had part-time). Less than 20% of CAHs had a full-time Director of Medical Staff and eight have a nursing home.

There were 6,307 surgeries at CAHs during 2007 (527 inpatient and 5,661 outpatient). Twenty six of the CAHs provide ultra sounds, 13 provide mammograms, 25 provide CT scans, 24 provide physical therapy, and eight provide dental services. Only six CAHs provide HIV/AIDS diagnostic and treatment services. Other services provided by CAHs include: community outreach programs, pain management programs, patient representative services, a patient education center, social work services, and teen outreach services. Eleven CAHs have a volunteers department.

All 27 CAHs have swing beds and 15 have Geriatric Psychiatry beds; 143 acute beds are used for Geriatric Psychiatry services. The average highest census is 19.48 and the average lowest census is 2.85; 21,847 admissions were recorded with 58,733 inpatient days and 21,785 discharges. The total number of admissions for persons 65 years and older was 10,413 and the total number of inpatient days for age group was 56,157. The total number of Medicare inpatient admissions was 13,447 and the total number of Medicare inpatient days was 65,701. The total number of Medicaid inpatient admissions was 3,818 and the total number of Medicaid inpatient days was 133,805. The total number of CAHs with RCH clinics was 19 with 109,675 RCH visits. The CAHs had 181,274 emergency room visits.

D. Critical Access Hospital Designation

The designation process for achieving CAHs status involves two steps: 1) submission of a satisfactory CAH Application (application discussed in part F of this section) to the CAH Certification Application Review Committee; and 2) successful completion of a CAH survey by the Division of Licensure and Certification of the MSDH. The CAH Certification Application Review Committee is discussed in part G of this section.

To satisfy state requirements for designation as a CAH, a hospital must meet all federal requirements for designation including successful completion of the survey by the Division of Licensure and Certification. Federal requirements for CAHs related to location, bed limits, distance from other hospitals, average length of stay, staffing, services, and network agreements are listed below:

Location, Bed Limits, Distance from Other Hospitals, and Average Length of Stay Section

1. Located in a state that has established a Medicare Rural Hospital Flexibility Program with the Centers for Medicare and Medicaid Services (CMS); and

2. Currently participating in Medicare as a rural public, non-profit or

for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989, to November 29, 1999; or is a health clinic or health center that was downsized from a hospital;

3. Located in a rural area or area treated as rural;

4. Located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles);

5. Maintains no more than 25 inpatient beds;

6. Maintains an annual average length of stay of 96 hours per patient for acute inpatient care; and

7. Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services seven days per week.

Medical Staffing Section

1. Staff must be sufficient to provide the services essential to the operation of the CAH (e.g., emergency services, direct services, and nursing services).

2. The CAH must have a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.

3. A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

Services Section

1. Inpatient and emergency care, laboratory and x-ray services are required. Some ancillary services (lab, radiology) may be provided part-time off-site.

2. Emergency services are required 24 hours a day, seven days a week. Staff in the emergency room must have emergency services training/experience.

3. A system must be in place with the local emergency medical system so that emergency medical personnel are aware of who is on call and how to contact them.

4. A doctor of medicine or osteopathy must be available by phone or radio 24 hours a day, seven days a week.

Networks Section
Facilities must have an agreement with at least one hospital that is a member of the network for:

1. Patient referral and transfer;

2. The development and use of communications systems;

3. The provision of emergency and non-emergency transportation; and

4. Credentialing and quality assurance.

Again, as indicated in the *Location, Bed Limits, Distance from other Hospitals, and Average Length of Stay Section*, CAH applicants must meet all additional CAH Conditions of Participation as established by CMS. Compliance with the CMS CAH Conditions of Participation is determined by the survey conducted by the Division of Licensure and Certification of the MSDH.

E. State Criteria for Determining a Necessary Provider of Health Care Services

A hospital that does not meet the federal mileage requirements to be certified as a CAH and is otherwise eligible for designation will be certified by the state as a necessary provider of health care services if it meets two (2) or more of the following criteria:

Criteria 1. The hospital is located in a county that is federally designated as a HPSA for medical care.

Criteria 2. The hospital is located in a county that is federally designated as a Medically Underserved Area (MUA).

Criteria 3. The hospital is located in a county where the percentage of families with incomes less than 100% of the federal poverty level is higher than the state average for families with incomes less than 100% of poverty.

Criteria 4. The hospital is in a county with an unemployment rate that exceeds the state's average unemployment rate.

Criteria 5. The hospital is located in a county with a percentage of population age 65 and older that exceeds the state's average.

Criteria 6. The number of Medicare admissions to the hospital exceeds 50% of the facility's total number of admissions as reported in the most recent Hospital Annual Report for the facility.

Any hospital not meeting two (2) of the above criteria may appeal the decision to the MSDH, Office of Health Policy and Planning. Appeals must be submitted in writing and will only be considered if the appeal provides sound evidence that future access to health care for the citizens in the facility's primary service area, as defined by the most recent patient origin study, will be jeopardized if it is not declared a necessary provider of health care services.

Facilities that meet the Necessary Provider Provision criteria are still required to complete the designation application process which includes: 1) submission of a satisfactory CAH Application to the Critical Access Hospital Certification Application Review Committee; and 2) successful completion of a CAH survey by the Division of Licensure and Certification of the MSDH.

F. Critical Access Hospital Designation Application

The CAH Designation Application will include the following information:

1. A community needs assessment which includes an inventory of local health services and providers;

2. Evidence of information activities to inform county and community residents, public officials, and health care providers of the proposed conversion of the hospital to CAH designation;

3. A financial feasibility study which will include:

    a. Audited financial statements and notes for the three most recently completed years;

    b. Adult and pediatric admissions, adult and pediatric patient days, deliveries, and inpatient surgeries;

    c. Outpatient and emergency room utilization data;

    d. An inventory of medical staff by name, age, and medical specialty;

    e. A three year CAH cost and revenue projection;

    f. A signed network agreement with a full service hospital detailing the facility relationships including:
        i. patient referral and transfer;
        ii. communications systems;
        iii. provision of emergency and non-emergency transportation;
        iv. arrangements for credentialing and quality assurance; and

v. other information and data which the Review Committee may determine is needed in order to make an appropriate recommendation.

G. Critical Access Hospital Certification Application Review Committee

A CAH Certification Application Review Committee will be established by the MSDH to review CAH applications and make recommendations to the State Health Officer regarding designation. The committee membership will be comprised of one representative from the Mississippi Office of Rural Health (MORH) located within the MSDH, one representative from the MSDH Division of Licensure and Certification, one representative from the Mississippi Hospital Association, and two hospital representatives appointed by the Mississippi Hospital Association. The State Health Officer may appoint representatives of additional groups to the committee.

H. Critical Access Hospital Relocation Requirements

Information regarding the guidelines for 42 CFR 485.610(c), concerning CAH location relative to other hospitals or CAHs, and 42 CFR 485.610(d), concerning relocation of CAHs with a necessary provider designation, is available at the CMS Web site. This site will also provide information about eligibility for the shorter, 15-mile standard due to mountainous terrain or lack of primary roads.

I. FLEX State Rural Health Plan Strategic Planning Process and Program Objectives

The Mississippi Office of Rural Health (MORH) engaged in a strategic planning process to update the FLEX State Rural Health Plan. The planning process included the assembling of a FLEX State Rural Health Plan Steering Committee (consisting of representatives of stakeholder groups) to provide insight and information on topics related to CAHs and on rural health in general. The process also included questionnaires completed by CAH administrators and administrators for hospitals eligible for CAH; a questionnaire completed by the state's Quality Improvement Organization; information from the MSDH Bureau of Emergency Services; information provided by the Mississippi Insurance Department Fire Services Development Division; and a questionnaire completed by EMS providers in the state. Meetings were held in September and October 2008 for this process.

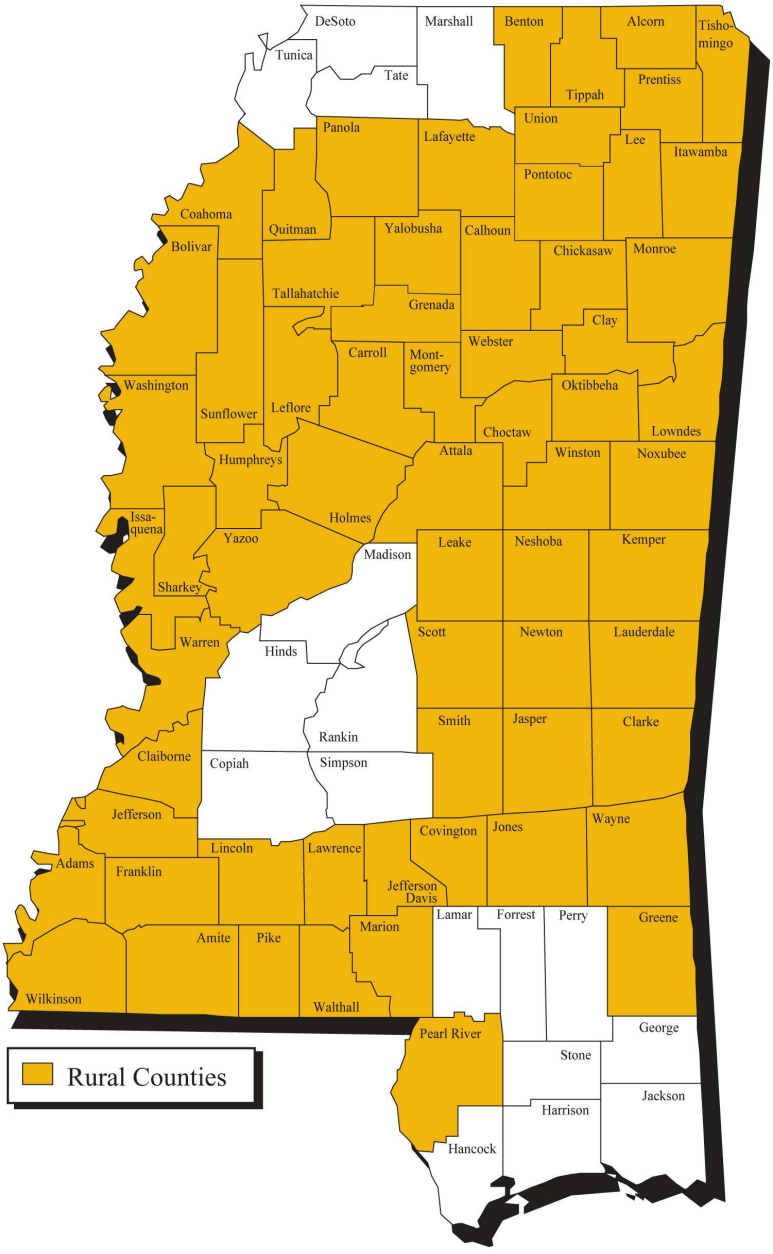
The FLEX Program's support of network development promotes regionalization of rural health services in the state. As a result of the strategic planning process and the statewide FLEX evaluation for the last two FLEX program years, the MORH will propose activities for the FLEX Program to address needs that focus on: 1) support for existing & eligible CAHs; 2) network development; 3) quality improvement; 4) EMS; and 5) designation of hospitals to CAH status. Performance measures will include: improvements in CAH financial indicators; access to coding and billing services and charge master review services; reduction of medication errors; availability of training opportunities; support for

individuals interested in becoming EMS professionals; improved quality in emergency rooms; assistance with adopting EHRs; facilitation of EMS training; and the availability of assistance for organizations' EMS needs.

J. List of Mississippi Critical Access Hospitals

A current list of Mississippi CAHs is available in APPENDIX C and at the MSDH website.

APPENDIX A
Map of Rural Counties in Mississippi



APPENDIX B
Rural Mississippi Counties in Alphabetic Order

Adams	Grenada	Lowndes	Sunflower
Alcorn	Holmes	Marion	Tallahatchie
Amite	Humphreys	Monroe	Tippah
Attala	Issaquena	Montgomery	Tishomingo
Benton	Itawamba	Neshoba	Union
Bolivar	Jasper	Newton	Walthall
Calhoun	Jefferson	Noxubee	Warren
Carroll	Jefferson Davis	Okitbbeha	Washington
Chickasaw	Jones	Panola	Wayne
Choctaw	Kemper	Pearl River	Webster
Claiborne	Lafayette	Pike	Wilkinson
Clarke	Lauderdale	Pontotoc	Winston
Clay	Lawrence	Prentiss	Yalobusha
Coahoma	Leake	Quitman	Yazoo
Covington	Lee	Scott	
Franklin	Leflore	Sharkey	
Greene	Lincoln	Smith	

APPENDIX C
List of Mississippi Critical Access Hospitals

Critical Access Hospitals	Date Converted
Choctaw County Medical Center (Ackerman)	May 1, 2003
Claiborne County Hospital (Port Gibson)	October 1, 2004
Covington County Hospital (Collins)	December 31, 2008
Field Memorial Community Hospital (Centreville)	October 1, 2002
Greene County Hospital (Leakesville)	December 31, 2005
H.C. Watkins Memorial Hospital, Inc. (Quitman)	January 1, 2004
Hardy Wilson Memorial Hospital (Hazlehurst)	December 31, 2005
Holmes County Hospital and Clinics (Lexington)	October 1, 2004
Jefferson Davis Community Hospital (Prentiss)	December 1, 2005
Kings Daughters Hospital (Yazoo City)	October 1, 2003
Laird Hospital (Union)	December 14, 2004
Lawrence County Hospital (Monticello)	February 1, 2002
Leake Memorial Hospital (Carthage)	January 1, 2004
North Sunflower Medical Center (Ruleville)	October 1, 2004
Noxubee General Hospital (Macon)	October 1, 2002
Patient's Choice Medical Center of Humphreys County (Belzoni)	July 1, 2003
Perry County General Hospital (Richton)	February 1, 2002
Pioneer Community Hospital of Aberdeen (Aberdeen)	September 1, 2001
Pontotoc Health Services (Pontotoc)	October 1, 2002
Quitman County Hospital (Marks)	January 1, 2004
S.E. Lackey Memorial Hospital (Forest)	September 1, 2000
Scott Regional Hospital (Morton)	October 1, 2005
Simpson General Hospital (Mendenhall)	September 30, 2004
Stone County Hospital (Wiggins)	December 1, 2001
Tallahatchie General Hospital (Charleston)	February 1, 2002
Tyler Holmes Memorial Hospital (Winona)	October 1, 2003
Walthall County General Hospital (Tylertown)	October 1, 2005